Food, Weight and Care in the Consultation

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Invisibilities of Food

Interactions around food, weight and eating that take place during health care consultations can bring up complex emotions. Exploring the context for these emotions necessitates looking at, and linking, discourses and debates around food and eating, and care. Above all, Fisher and Tronto's (1990) four dimensions of care can shed light on different aspects of the consultation: On the side of the health professional, 'caring about' (attentiveness) aims to be mindful of the other's need; within the biomedical paradigm, this could be seen as the doctor or nurse noticing that the patient is overweight and therefore in need of help. However, it might be more fruitful to interpret 'caring about' as attending to the patient more holistically, without prioritizing weight. 'Caring for' implies the doctor or nurse taking on responsibility for the patient, and initiating the actual work of 'caring': the dialogue of the consultation which should include talking about food and eating in a sensitive manner. However, the care receiver is also involved by being receptive and judging the effectiveness of care. As food and eating are an important aspect of maintaining health in everyday life, 'caring about' what other people eat becomes an important aspect of 'caring for' the patient.

Setting aside the debate over whether weight loss itself is desirable, achievable in the long term or salutogenic (Aphramor 2005), this chapter initially set out to explore the entanglement of food and care in primary care consultations.[1] However, it soon became apparent that food is a curious absence in this literature, with weight taking centre stage.

[1] I aimed at broad reading rather than a systematic approach, with a review of qualitative and sociological journals backed up by a *Medline* and *CINAHL* search (weight/ obesity plus primary care/ consultation/ doctor-patient relations), followed by snowballing from citations. Similar to qualitative reviews with a more systematic approach (cf. Malterud and Ulriksen 2011; Mold and Forbes 2011), most articles discussed here are from the UK, US, Australia or Scandinavian countries and the majority of participants are female and white.

Researchers looking at experiences of giving and receiving healthy eating advice have noted a curious slippage between 'healthy eating' and 'weight management', with healthy eating campaigns, dieticians, GPs and patients focusing on weight rather than what is eaten (McClinchy et al. 2013). While qualitative research has explored the complex individual meanings attached to food and eating practices, e.g. as an expression of personal memory and nostalgia, (see for example Ferzacca 2004, Lupton 1994), interactions in the clinic sometimes boil down to exhortations to 'eat less':

> He said, 'Well, you just have to stop eating'. And I said, 'If it would have been easy for me, I would have done it a long time ago' (Merrill and Grassley 2008: 143).

> I went to see my doctor and he gave me the following comment: 'Eat less and exercise more and stop complaining!' (Gronning et al. 2013: 277).

Where food does appear, it emerges as a topic that doctors and nurses use to talk about their patients. This tends to come with a strong moral framework that differentiates between good and bad foods (see Lupton 1996). For example, cream cakes and biscuits are mentioned by professionals to illustrate patients' refusal to take on board their recommendations. Meanwhile, 'good foods' are introduced to give an exaggerated picture of patients being untruthful or in denial about their eating, with patients saying they are eating nothing but fruit and vegetables or lettuce. Both these usages are unlikely to lead to a meaningful discussion about food and eating in the consultation.

To begin with, I will trace how this slippage from food to weight is encouraged by a wider stigmatizing cultural and clinical focus on a need to 'tackle' what is widely, but possibly unhelpfully, termed an 'obesity epidemic' (Flegal 2006, Mitchell and McTigue 2007). This concept frames policies and practices of care, with 'caring about' obesity shaping ways of 'caring for' patients. I will argue that caring about obesity without also caring about

the complexities of food and eating creates a disconnect between what both carers and cared-for 'ought' to do and their lived realities (see also Zivkovik et al. this volume). In turn, this gives rise to difficult emotions of anger and frustration that complicate discussions around food and eating. This chapter, then, will look at the intersections between weight discussions, emotions and bodies, exploring why these discussions are so extremely uncomfortable for doctors, nurses and patients.

The 'Obesity Crisis': From Caring About to Caring For

Consultations on food and weight take place in the familiar context of obesity as a major public health crisis, with both the academic and professional literature, as well as the mass media, full of alarm on the impact of the 'obesity epidemic' (Campos 2004) and the cost especially to publicly-funded health services (Wang et al. 2011). A policy paper by the Academy of Medical Royal Colleges (2013) is one of many voices comparing the work of anti-obesity campaigners to those that championed tobacco control in earlier decades:

> Like those doctors who realised that smoke-filled homes and offices of the 1950s were creating a health time-bomb, we demand action today. Just as the challenge of persuading society that the deeply embedded habit of smoking was against its better interests, changing how we eat and exercise is now a matter of necessity (Academy of Medical Royal Colleges 2013: 14).

Food choice, however, is more than just a 'deeply embedded habit'. Sociologists and anthropologists have widely explored the myriad social, ritual and interactional functions of food (see for example Lupton 1996, Visser 1986, Wilk 2010). Furthermore, while tobacco can be simply, however painfully, 'cut out', food sustains life: 'People do not need to smoke, but they do need to eat'; this common-sense statement has been used by the WHO Director-

General to urge the worldwide development of healthier food environments (Chan 2011). Yet, current health policy initiatives tend to focus on the individual rather than the environment. A case in point is the UK based 'Making Every Contact Count' (MECC) which recommends that primary care professionals raise weight and eating with their overweight patients as often as possible. This means that 'caring about' what people eat could become an important part of doctors' and nurses' professional roles of 'caring for' patients.

However, a problem arises in the transition from 'caring about' to 'caring for' (officially taking on responsibility for the patient), especially when the details of that care are pre-figured by guidelines. For example, the MECC programme stresses the importance of empowering individuals and helping them to make their own decisions (see for example the training materials published by NHS Yorkshire and the Humber 2010). Yet, it can be assumed from the overall climate of urgency that weight will often be raised regardless of the original reason for the consultation and the patient's wishes. This matters as 'caring about' includes focusing—for the moment—exclusively on intuiting what the individual person feels and needs: attentiveness (Fisher and Tronto 1990), or empathy (Mercer and Reynolds 2002). In their extensive analysis of 'kindness' in modern health care, Ballatt and Campling describe a virtuous cycle in which an underlying tenor of kindness (warmth, sympathy, compassion) can lead to attentiveness to the individual patient (noticing, thinking, feeling, learning), which in turn enables attunement (responsiveness, sensitive caring) and fosters trust and improved co-operation between patient and health professional (Ballatt and Campling 2011: 45).

Qualitative research with overweight people, however, has found that this focus on what the patient feels and needs is often not realized in practice (Chugh et al. 2013, Tischner 2013). Since raising the topics of weight and eating is framed as potentially lifesaving by health policy, accepting responsibility for the patient ('caring for') can imply that the doctor

or nurse now feels responsible for the patient's eating; this leads the health professional to 'care about' obesity rather than the individual patient. This can lead to 'apparently appropriate advice [being] perceived as patronising by patients' (Malterud and Ulriksen 2011: 1).

Two exploratory frameworks are particularly valuable to contextualize the qualitative literature around consultations on weight. One very clearly is the existence of weight stigma and the 'spoiled identity' (Goffman 1963) of obesity, which will be discussed in more detail later in this chapter. The other is the embodied experience of being overweight, which is closely linked to emotions and relationships around food (Tischner 2013). Qualitative studies offer rich descriptions of emotions unleashed during consultations which, with the unequal distribution of power in the consultation (Foucault 2003, Turner 1987), could inhibit the free, empowering dialogue envisioned by MECC campaigners. The accounts of study participants also suggest that emotions are often not expressed in the consultation, especially when they are 'difficult' emotions such as anger. It is however possible to imagine that they contribute to overweight people delaying to seek help for other health problems (Mold and Forbes 2011).

The literature on doctors' and nurses' thoughts and experiences around raising weight in the consultation shows that, while many see making patients aware of their weight and the associated health risks as part of their duty to provide care (Hansson et al. 2011), some are also aware of the potential sensitivity of the topic. This could mean refraining from possibly-upsetting terms, and sometimes avoiding the topic altogether (Brown and Thompson 2007). Doctors and nurses may deliberately choose not to raise the topic of weight in order to avoid opening a 'Pandora's box of psychological problems' (Michie 2007: 523). On the other hand, these consultations emerge as difficult spaces for all involved. Patients might feel patronized when being told what (not) to eat. However, doctors and nurses can feel vulnerable too,

despite the power imbalance in the clinic discussed by Foucault and others. Trying to instigate behaviour change is often tinged with frustration when the patient does not lose weight. As weight is always visible and cannot be disguised, practitioners' own struggles with their body can come uncomfortably to the fore when discussing weight and eating.

Primary care is different from other health encounters, such as with dieticians, in that there is the potential for an ongoing discussion around weight with the same doctor or nurse. Both patients and health professionals bring the memory of earlier discussions about weight with them, and these are embedded in personal experiences over the whole lifecourse. Not only do patients often have a history of struggling with weight that goes back to their childhood, but also a history of consultations about weight (in my own case, this goes back to my mother being given a booklet titled *Your overweight child* when I was thirteen). Some patients may expect the history of past consultations to be taken into account when eating and weight is mentioned; doing so might make these discussions more fruitful and less painful.

Anger

In accounts from overweight research participants, anger towards a doctor or nurse is often palpable, emerging in the literature as well-honed stories outlining the impact of an insensitive or thoughtless remark in the consultation. As if in an attempt to diffuse the rawness of the pain felt by the teller, humour is often used when these stories are recounted. While open discrimination and humiliation by doctors or nurses is rarely recounted, weight stigma can still overshadow interactions with health professionals when the patient feels angry at being positioned as lazy and stupid:

> [Female participant]: My [overweight] friends and myself are all people who've got degrees […] we can read the literature […] and we fully understand what we should or shouldn't eat (Tischner 2013: 81).

Ostensibly neutral clinical terms such as ‘obese’ can also provoke negative emotions (Gray et al. 2011):

> [Female participant]: ‘Morbidly obese’ I hate it. I hate that term. It just plays hell with my mind. I’m not morbid, I’m not ugly, I’m not a morbid person; I’m a happy person (Thomas et al. 2008: 324).

This account shows how being labelled ‘morbidly obese’ can be perceived as a hurtful and anger-inducing judgement of the whole person. As hinted above, considerable annoyance may also be caused by a doctor or nurse introducing obesity without asking about the patient’s history or any previous attempts to lose weight. This does not only move the consultation away from the immediate needs of the patient but also creates a disjoint between the consultation and the experience of a lifetime of struggling with weight:

> [Female participant]: The doctor said, ‘Well, your blood pressure is high. You need to lose weight’. And I said, ‘I realize that’. He said, ‘Well, you just have to stop eating’. And I said, ‘If it would have been easy for me, I would have done it a long time ago’. And he said, ‘Well, you just need to learn how to do that’. And so to me it was like an impasse … I walked out of there … and I thought, ‘The hell I will!’ (laugh) (Merrill and Grassley 2008: 143).

While this discussion creates a strong response of anger and rebellion, other patients recount feeling frustrated and angry by only being given standardized information without regard to past attempts at losing weight:

> [Female participant]: I think if they listened and respected you as an individual instead of lumping fat women together … You should be more interested in hearing

> me say, 'I've tried A, B, C, and D. How do we get to G, F, H, I, J?' (Chugh et al. 2013: 424).
>
> [Male participant]: I went to see my doctor and he gave me the following comment: 'Eat less and exercise more and stop complaining!' I thought 'you don't understand jack shit'. I asked him if he expected me to pay for the consultation and he said yes. I told him to forget about it and I haven't seen him since (Gronning et al. 2013: 277).

Interactions that imply a perception that every health condition is put down to a person's weight may cause not just anger, but also worry that other problems might be overlooked:

> [Participant, gender unclear]: you think, 'Well, nobody's going to tell you what's wrong if you've got something wrong with you because they're putting everything down to your weight,' and to me that's wrong (Brown et al. 2006: 670).
>
> [Female participant]: I've had medical professionals tell me that problems I've had are because of my weight when I've had the same problems for a number of years before I was at this weight […] people try and make it easy for medical professionals not to address people's actual real health problems and just say well if you go away and lose weight, you know, then you'll be better (Tischner 2013: 91).

Both male and female participants cited above show a strong sense of anger; because anger is a difficult emotion for people in a situation of unequal power, and especially for women (Kring 2000), this may be more problematic for female patients. In the accounts above, anger is not expressed in the consultation, although some doctors and nurses recount how patients may become 'furious' if their weight is raised when they come in with an unrelated issue (Hansson et al. 2011). Nurses also realize that some patients may stay away once it becomes clear that they will be weighed (McClinchy et al. 2013).

It seems a common-sense proposition that some health professionals should respond emotionally to these consultations as well. The following accounts show health professionals feeling frustrated and annoyed as the patient does not lose weight:

> [Health professional]: But it's when you get 6 weeks down the line and they're still not losing weight and they swear blind they're eating nothing that you start the struggling and you think, well, where do we go now? (McClinchy et al. 2013: 502).

> [Male GP]: You can lead a horse to water but you can't stop it eating cream cakes (Gunther et al. 2012, p.98).

> [GP] I end up feeling it isn't possible for them to do it [lose weight], so I feel annoyed with them for not just doing it (Epstein and Ogden 2005: 752).

While these responses could be seen as not very 'caring', Ballatt and Campling (2011) clearly link this kind of negative feelings to discourses around care. They describe how feelings of being a failure due to an inability to make a lasting difference— compounded by a target driven work culture—can lead to dislike and resentment towards patients. As these emotions contradict the self-image of 'caring' professions, they are often not voiced and doctors and nurses can feel guilty about having them. In this context, it is 'all too easy to feel furious with patients who appear to be undermining all efforts to help them' (ibid.: 60).

In the accounts discussed here, professionals do not openly speak of showing their anger and frustration towards patients. However, one GP does discuss using anger as a motivator:

> [Female GP]: I express frustrations to my patients sometimes. … I think they have to see us getting a little bit upset or angry … I think some patients are moved by that, and I think it does get them going a little bit (Gudzune et al. 2012: 154).

Other health professionals described how they could retreat behind blocking communication and standard advice without expressing anger (ibid.), while patients might still perceive criticism from the tone of the doctor's voice:

> [Female participant]: So, you're on the receiving end of factual comments that are—the intonation is disapproving. … It's not what you say; it's how you say it (Chugh et al. 2013: 424).

The experiences described above are highly personal but can still be divided into two broad typologies that seem especially prone to producing anger and frustration. On the one hand, a disconnect appears between the patient's and the health professional's understanding of what is important for the consultation, for example when weight is raised out of the blue, or when other health issues are ignored in favour of weight. This means that 'caring about' obesity trumps 'caring about' the patient. On the other hand, the persistence of weight over time may wear down both health professionals and patients: 'it's an issue every time they come in' (Brown and Thompson 2007: 538). While patients may feel that their lifelong struggle with weight is being ignored, doctors and nurses are frustrated that patients seem not to be doing enough to help themselves. However, some health professionals acknowledge that rapport and trust is built up over time, with discussions of weight a 'continuous conversation over many years' (Gudzune et al. 2012: 154). In order to lead to the real partnership envisioned by Gudzune et al., this conversation should acknowledge a patient's lived experience of weight as well as the history of earlier discussions.

Shame, Guilt and 'Saving Face'

The stigmatized nature of obesity is acknowledged by many qualitative studies of the patient experience (see Gronning et al. 2013, Malterud and Ulriksen 2011). What makes the experience of weight stigma particularly distressing is the constant visibility of obesity.

While someone who is smoking or regularly drinking alcohol may be able to 'pass' as healthy at times, the overweight body is always on display with some overweight people feeling constantly monitored, for example when eating in public or shopping for food (Tischner 2013). This phenomenon may be reinforced by the ubiquity of de-humanized representations of 'headless fatties' in the media (Cooper 2007). The moral implications of obesity, its conflation with gluttony and laziness and its use as a vehicle for uneasiness with a society driven by growth and consumption (see for example Bordo 2003), work to position the overweight person as morally deficient. This can take the form of the body as 'metonymically' standing for the whole person which is then seen as morally deficient (Tischner 2013: 115). Overweight people interviewed about their experiences often stress that they are more than 'just' their weight but that they feel judged by other members of the public: 'People think you're stupid. If you're fat you're stupid or you're a pig … you're a glutton. You gorge yourself' (Brown et al. 2006: 669).

When applying the concept of weight stigma to health interactions, some researchers focus on health professionals' stigmatizing attitudes which, although not always conscious or directly expressed, can lead to patients experiencing labelling, stereotyping or discrimination. This, in turn, may render patients avoiding healthcare or screening (Malterud and Ulriksen 2011, Mold and Forbes 2011). On the other hand, some doctors and nurses were seen to respond compassionately to their patients' distress:

> [Female GP]: There comes a time when you get so disappointed with yourself, because you just can't lose weight. You think you've done everything, and you still can't like yourself. You lose confidence (Hansson et al. 2011: 8).

The concept of stigma resulting in a 'spoiled identity' (Goffman 1963) could be instrumental in understanding why some patients readily accept that only they are to blame for their

weight and any medical conditions possibly related to it (Malterud and Ulriksen 2011), while others attempt to resist the stigmatized identity (Tischner 2013). Gronning and colleagues (2013) link obesity stigma to Goffman's theory of a split between a socially acceptable, visible 'front stage' and an invisible, private 'back stage' persona (Goffman 1969) to explore how overweight people manage shame and blame. As weight is always visible, it cannot be hidden back stage; however, people can avoid presenting themselves as lazy and greedy by explaining their weight problem through factors over which they have little or no control, such as physical or mental problems (Gronning et al. 2013: 274). Others may portray themselves as 'addicted' to food or not in control of their eating as their families reject foods they dislike (see for example Peel et al. 2005). However, doctors may interpret a self-presentation as powerless as pushing responsibility towards *them*:

> [GP]: I think a lot of them believe that someone else is going to do the job for them. [...] They put the responsibility on me; I'm the one who's going to fix it so they lose weight (Hansson et al. 2011: 7).

As the stigmatized identity of obesity is strongly linked to ideas of responsibility for the self, some overweight people resist stigma by positioning themselves as a 'responsible fat person' who engages in activities seen as healthy in a medical paradigm, such as keeping fit or eating lots of vegetables (Tischner 2013: 77). Taking this position can also lead to the consultation becoming difficult as health professionals believe that the patient would surely lose weight if they behaved in this way:

> [Nurse]: He tells me that he eats nothing but fruit and vegetables, and that he can't understand why he hasn't lost any weight […] when a patient says that to you, it's very difficult to say, 'Look, I don't necessarily believe what you're telling me

> because, if you did all that, you'd be losing weight' (Brown and Thompson 2007: 538).
>
> [Nurse]: They often say 'I don't understand it, I don't eat anything', but actually we know they do (Hansson et al. 2011: 7).
>
> [GP]:…almost a classic response from women who want to lose weight, but are big, is the sort of 'but I only eat a lettuce leaf' approach (Epstein and Ogden 2005: 752).

These accounts outline a disconnect between patients' narratives and what the professional 'sees' and 'knows'. Instead of exploring what patients mean by their statements and understanding attempts to save face and avoid shame, health professionals seem to interpret them as being untruthful. This, in turn, can lead to the consultation becoming even more difficult as they do not wish to confront the patient with accusations of lying. The hyperbole in recounting unrealistic patient narratives ('only a lettuce leaf') seems to express a great deal of frustration. The following account in which a GP recalls discussing eating with people who have recently consulted a dietician is very telling in this context:

> [GP]: [The patient said] 'Well, [the dietician] said I'm doing fine' and you can see on the screen 'cut down on cakes and biscuits'. The interpretation of what's been said to them which has been a clear message and they come to me with they are 'doing fine', they never come to me and say 'they said I should eat less fat' or 'I should stop having chocolate'. They say, 'they told me to eat regularly'(McClinchy et al. 2013: 502).

Here, the GP seems to interpret the patient's narratives as wilfully ignoring professional advice, which is especially glaring as the message given by the dietician is clearly visible 'on the screen' (again, there is a difference between what the patient says and what the

professional sees). However, they can be interpreted differently, for example as focusing on positive messages ('doing fine'; 'eat regularly') while avoiding negative messages ('cutting down' 'eating less' or 'stopping'). Following Gronning et al. (2013), it could also be seen as an attempt to save face (would anyone gladly report to their doctor that they were told to stop eating chocolate?)

The accounts cited in this section illustrate how feelings of shame and attempts to save face can make consultations around weight very fraught. A focus on visible and measurable weight serves to obscure lived complexities around eating. Health professionals privileging the visible and measurable weight and the report on the computer screen may set up an antagonistic relationship with their patients who feel that their struggles with weight or to achieve a healthier life are ignored (see Tischner 2013):

> This construction [by health professionals] of obese people as fundamentally unreliable, and even deceitful, fails to take account of the shame and guilt which might inhibit full disclosure of consumption, but also discredits people's lived experiences and beliefs of their own bodies as responding differently to food (Throsby 2007: 1565).

Many doctors and nurses seem to find it difficult to find space for 'caring about' as the need to 'care for' patients, e.g. by preventing cardiovascular disease, looms large. Doctors' accounts tend to focus on the concept of responsibility (describing attempts at saving face as denying responsibility or even pushing responsibility on to them). An additional dynamic seems to operate between doctors and nurses, with GPs feeling that patients look to them to 'fix' their problem (Hansson et al. 2011), and nurses in turn feeling frustrated that GPs offload responsibility onto them, leaving them in the role of intermediary between doctors and patients (Mercer and Tessier 2001, Wright 1998). However, some health professionals

are able to discuss the often psychological reasons for being overweight rather than focusing on responsibility:

> [Health professional]: I tend to talk quite a bit about the psychology: a lot of them know what they're doing wrong but they just can't stop doing it (McClinchy et al. 2013: 502).

> [Female GP]: It's very much a question of comforting words or, so to speak, off-loading the blame (Hansson et al. 2011: 6).

Doctors and nurses taking this approach might make the consultation less likely to lead to the feelings of guilt, shame and frustration described above. Meanwhile, for patients, removing the link between talking about weight and feelings of guilt and shame could make it easier to seek a frank and open discussion of eating, thereby reducing the invisibility of food.

Visible Embodiment in the Consultation Relationship

As discussed above, another important aspect of obesity is its visibility, not only in the literature, as noted, but also corporeally. In the consultation, the doctor or nurse is given an immediate cue for questions about weight (and possibly also for the assumption that the patient is not aware that they are overweight as they would aim to lose weight if they were):

> [Nurse]: Every time they come in, it's an issue, is very demoralizing for the patient and probably negative to the relationship we have with them (Brown and Thompson 2007: 478).

However, discussions of weight also put the body of the doctor or nurse centre stage. This can work to unsettle the 'affectively neutral' doctor role highlighted by classical medical sociology which is non-emotional and non-judgmental (Bury and Monaghan 2013); this

implies that the doctors is perceived as disembodied while the body of the patient is foregrounded as an object of examination and treatment.[2] A focus on the body of the health professional becomes especially difficult if they are themselves overweight as it is increasingly seen as their responsibility to be of a normal weight (Monaghan 2010). Therefore, the authority of the doctor or nurse as expert could suffer if they were seen not to follow their own advice:

> [Male participant]: If [the practitioner] were themselves in shape and fit and healthy and enthusiastic and driven and happy within themselves, I think that would all paint a picture of someone who is a success at what they are preaching (Leske et al. 2012: 312).

Brown and Thompson's (2007) study of the impact of nurses' own body size on their interactions with obese patients provides additional examples of the uncomfortableness of nurses' embodied presence. Similar to the overweight patient who discerns criticism in the doctor's voice, the gaze of patients can affect the nurse's self-image and confidence without anything being said:

> [Nurse]: With some patients, talking about healthier eating issues, I can see them focus on my stomach... I do feel very conscious of and sometimes I think maybe I should just move into something and go and do something else where I don't have to feel self-conscious (Brown and Thompson 2007: 540).

Some overweight nurses aim to overcome this by discussing their own struggles with weight in an attempt to create rapport with patients (Brown and Thompson 2007, Gudzune et al. 2012). This could be a positive example for 'caring about' patients as sharing the struggle

[2] Some sociologists have also outlined a gendered dimension to this dynamic, in which the doctor's role is aligned with rationality and masculinity (DasGupta 2003), whereas the role of the nurse is more complex as there is a strong link to caring for the body of the patient and taking on a maternal role (Allan (2005).

with weight also acknowledges lived realities and implies that it is a long-term process. However, there is also the worrying possibility that rapport-building between nurses and female patients may reinforce gendered stereotypes along similar lines to 'fat talk'. First described by Nichter (2000), 'fat talk' is self-depreciating discussion of weight which creates rapport in social interactions between women or girls. The flip-side is that self-esteem is reduced and beauty norms are uncritically perpetuated. In discussions between nurses and patients, these patterns could possibly work to endanger rapport rather than enhancing it: Brown and Thompson suggest that nurses who are critical of their own weight might be, in turn, more critical of their patients.

While a similarity between health professionals' and patients' weight could uncomfortably blur the boundaries between them as well as creating rapport, thin health professionals might be seen as not able to understand patients' struggles:

> [Nurse]: If they don't perceive you as ever having a problem with weight or with what you eat, then they obviously think you can't possibly understand what I'm, you know, on about. So it can be difficult (Brown and Thompson 2007: 539).

The visual nature of the body then sets up the potential of caring relationships such as these developing into no-win situations in which the body of the health professional is always 'wrong': if they are overweight, their authority could suffer and their advice could be taken less seriously. If they are not overweight, they could be seen as unable to understand a patient's situation, thereby increasing the distance between them. On the other hand, creating rapport over weight issues could also be problematic as similarities between nurses and patients may be too easily assumed (Brown and Thompson 2007).

Compassion

So far, I have focused on emotions that make consultations around weight difficult, especially where the interaction produces strong responses such as anger or frustration in both patients and health professionals. Yet, the literature also shows that these situations can be at least partly overcome by doctors and nurses showing compassion for the patient. Similar to the 'kindness' described by Ballatt and Campling (2011), compassion is an underlying ethos of care closely linked to 'caring about' the patient, closely attending to their need as a fellow human being (Bradshaw 2011). [3] However, as compassion also has an emotional component, it can be difficult to sustain, especially towards people that seem unwilling or unable to improve their own health. Some argue that the obesity discourse increases its status as a 'self-inflicted' condition and therefore makes it harder to feel compassion for the overweight (Fraser et al. 2010, Magliocca et al. 2005). Clearly, its absence can be acutely felt by some overweight people:

> [Female participant]: Educate the doctors how we feel. Do a video letting them look, this is the way that we feel. I'm a full-figured woman, but I have feelings. I care. I want you to care (Chugh et al. 2013: 424).

However, the difficulty of compassion might also be linked to the particular dynamics of the doctor-patient relationship in primary care, not least when there is no opportunity to resolve the problem:

> Once the person says, 'well, I'd like some help to lose weight but actually I don't want [referral to commercial weight loss programmes]' then you're absolutely right the cupboard is bare (Aveyard 2014: no page).

[3] As compassion has been included into official health policy for nurses (Commissioning Board Chief Nursing Officer 2012), there now is the thorny question of whether it can be trained and tested; it might even constitute emotional labour if prescribed by official bodies (see for example Aldridge 1994). Ann Bradshaw (2009) describes it as a virtue, i.e. a synergy of intention and practice aimed towards care for the stranger; this is a definition I would like to use here as it is closely linked to Tronto's (1993) description of care as both personal 'caring-about' and practical/ institutional 'caring-for'.

Chew-Graham and colleagues (2004) argue that patients who seem unable or unwilling to summon the motivation to recover are particularly toxic for the doctor-patient relationship, as they make GPs feel powerless to bring about positive change. Moreover, an unrealistic emphasis on a good personal relationship between doctors and patients only adds to the pain and frustration for GPs who are unable to achieve it. This pattern is similar to the cycle of emotional overinvestment in the caring role, followed by negative feelings towards patients and guilt about these feelings described by Ballatt and Campling (2011). However, others claim that, given the right tools, doctors and nurses can overcome this impasse by acknowledging and validating difficult emotions (both their own and those of their patients) and negotiating solutions in partnership with the patient (Cannarella Lorenzetti et al. 2013, Halpern 2007). In the context of consultations around weight, this could move the consultation towards a focus on lived experience which should include a discussion of lived realities of food and eating; however this is likely to rely on an ongoing relationship as there is very little time in the individual consultation.

A different conversation?

Any conclusions regarding what is happening 'in the consultation' drawn from published qualitative research obviously need to be treated with caution. As I was looking for anything related to discussions around food and emotions during consultations in articles often focusing on other issues, I needed to 'cherry pick' passages and quotes that are illuminating in this context. Most researchers look at either health professionals or patients in isolation; while some studies draw on accounts from both, they do not elicit reflections on a shared consultation. There are publications in other fields that illustrate how this could work, for example Green et al.'s (2009) in-depth exploration of one doctor's and her patient's interpretation of what was seen and said when they discussed a breast ultrasound image. Throughout the literature there are plenty of examples of good care, either framed as

compassion or as a creative tinkering and problem-solving process as described by Mol (2009). However, trying to talk about food and weight can be an intensely uncomfortable situation for both health professionals and patients, often ending with the patient not feeling 'cared for'.

While I have described the development of clashing emotional responses above, these need to be set in the context of power in the consultation. Classically, 'the clinic' has been theorized as empowering the doctor who enacts power by 'his' dehumanizing gaze (Foucault 2003) or performs a role of parental authority towards a childlike patient (Parsons 1951). This could be exacerbated by patients feeling treated like naughty children and therefore regaining a sense of autonomy by disregarding health professionals' recommendations (Broom and Whittaker 2004). However, the picture here is more complex as doctors, nurses and patients are restricted by external social forces (guidelines, time allotted for the consultation) and more recent theories also focus more on interactional and relational forms of power. In Kwok-Fu Wong's (2003) four-part model of power, the traditional understanding of power flowing from the professional is related to the most 'negative' force of power (power-over). As the gatekeeper to further treatment, the GP has some power over the patient, which becomes noticeable from patients' fears that valid health concerns may be overlooked because of an overwhelming focus on weight. The situation becomes more equalized when looking at power-to (to act or effect change) as health professionals have power to advise and the patient equally has the power to ignore advice; however, this can be a very negative power that does not affect the professional very strongly and can lead to 'irritability and dysfunctional frustration for a considerable amount of time' (Tuckett 1976: 192).

The more positive forms of power (power-from-within and power-with) are more difficult to attain in this situation. Firstly, power-from-within requires the development of self- confidence and self- acceptance that is diametrically opposed to the dynamics of weight

stigma; secondly, power-with requires solidarity and therefore mutual support by overweight people or a strong collaborative relationship. This is seen in some of the health professionals' and patients' accounts but does not seem the norm for discussions of food and weight. What appears more pervasive is a dynamic of enacted powerlessness on both sides, leading to stagnation and frustration, where obesity itself seems to hold the greatest power. This can only be exacerbated by the discourse of obesity as an existential crisis with health bodies and politicians urging that 'something must be done'. On the other hand, there are opportunities for starting 'a different conversation':

> [GPs] might say, 'well it would help your blood pressure if you lost weight or you'd help prevent a heart attack if you lost weight' […] probably the most helpful thing you can do […] is to say, 'would you like some help to lose weight?' And then you're into a kind of a different conversation (Aveyard 2014: no page).

While this approach moves away from using negative motivation and threat to achieve lifestyle change, it still assumes that patients will want or need 'help' and that the GP can provide it. In contrast, Iona Heath, a general practitioner well known in the UK as a strong critic of over-zealous intervention, has described 'the art of doing nothing' as essential to her role:

> I met a young doctor [who] is also a brilliant musician … she had written a piece of electronica music that she played for us. It had a repeating line … 'I know I can see you through this'. As this phrase repeated in the music, I slowly realized how different this statement is from the more usual 'I know I can help you with this ' and the difference is about witnessing and about being there when there is little help to be had. It is an offer of companionship, of solidarity and a promise not to run away. It is part of the art of doing nothing (Heath 2012: 244).

The ‘art of doing nothing’ includes thinking, waiting, listening, noticing, ‘being present’ as a compassionate human being and acknowledging that sometimes the practitioner cannot ‘help’, for example because the sources of the problem lie in the socio-economic environment and not the individual. In the case of consultations around food and weight, a ‘doing-nothing’ approach might include listening to the patient’s history around food and being genuinely interested in the meaning of food in their life. It may also include political campaigning for a less obesogenic environment as ‘we have an obligation to speak out for those who have no voice and to describe to politicians and policy-makers, as often as we can, how their policies play out in the realities of daily life’ (ibid. 244).

Another approach to take would be to enact a paradigm shift away from a ‘weight centred framework’ that seems to be effective only in the short term while leading to negative consequences such as weight cycling and other health goals being ignored (Aphramor 2005). Bacon and Aphramor (2011) have argued that a ‘Health at Every Size’ approach should focus on improving health by helping patients to build healthy eating and physical activity into their everyday lives, regardless of weight. A similar solution has been proposed for diabetes care:

> We find that if physicians view themselves as experts whose job is to get patients to behave in ways that reflect that expertise, both will continue to be frustrated. However, when health professionals let go of the traditional view of provider-centred care and recognize the patient as the primary decision-maker, they become more effective practitioners (Funnell and Anderson 2000: 1709).

I started this chapter with an interest in the links between discourses of food and care and the dynamics played out in the consultation. This was grounded both in my own experience and the existing qualitative research on overweight people’s perspectives. I found that interactions around weight could be intensely uncomfortable as they can unleash emotional responses in

both health professionals and patients and have the potential for a mutual enactment of powerlessness in the face of obesity. Discourses of care are crucial to understanding why this happens. Unrealistic demands on the 'caring' professions could lead to exhaustion and becoming unable to care. 'Caring for' the patient is often dominated by struggles around assigning responsibility for obesity (to the patient, doctor or nurse). This means that 'caring about' the patient is superseded by modes of 'caring for' the patient dominated by attempts to effect behaviour change with little regard for the emotional aspects of food and the lived experience of being overweight. A way out of this impasse could be a focus on 'caring with', an underlying ethos of solidarity and trust between carer and cared-for (Tronto 2013) . 'Caring with' includes letting go of trying to make patients lose weight and moving from an intervention centred framework to a focus on the individual history and experience (including earlier discussions about weight). This would hopefully open the way to a real conversation about food and eating in the consultation.

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